STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a Post Survey Revisit (PSR) to the PSR completed on 5/4/2011, to the Investigation of Complaint IN00088045 completed on 3/28/2011. Complaint IN00088045 -Corrected. Unrelated deficiencies cited. Survey date: July 27, 2011 Facility number: 004442 Provider number: 004442 AIM number: NA Survey team: Gloria J. Reisert, MSW Census bed type: Residential: 34 Total: 34 Census payor type: Other: 34 Total: 34 Sample: 05 These State Residential Findings are cited in accordance with 410 IAC 16.2 Quality review completed on July 29,	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2011 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0121	(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure a health screen	R0121	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists	09/05/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was obtained at the time of employment or within one (1) month or tuberculin test were completed for 3 of 5 new employees (E #1, 2, and 3) in the sample of 5 new employee files reviewed. Findings include: Review of the employee files on 7/27/11 at 3:30 p.m., of new hires between 6/16/2011 and 7/27/2011, the following was noted: 1. E #1 [Employee] was hired on 7/3/2011 as an LPN [Licensed Practical Nurse]. Documentation was lacking of a health screen having been completed prior to employment. 2. E #2 was hired on 7/12/2011 as a Certified Nursing Assistant [CNA]. Documentation was lacking of a health screen having been completed prior to employment. Review of the employee file indicated the employee had received a second step PPD at her prior employment which had been read 7/21/2010. There was no documentation of current TB test. During an interview with the Wellness Director at 4:40 p.m., he indicated that although the employee was scheduled to work, she would be taken off the schedule until her health screen and annual TB test		or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. **R 121** **410 IAC 16.2-5-1.4 (f) (1-4)** **Personnel** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Employee #1, #2, and #3 had a health screen completed on 8-4-2011. Employee #2 had a tuberculin skin test administered by a licensed registered nurse. Employee #1, #2, #3, and #4 had their corresponding job descriptions reviewed, signed, and placed within their files. Employees #1, #2, #3, and #4 received re-education as to our abuse policy and procedure. **How the facility will identify other residents having the potential to be affected by the same**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were completed as one had not been performed. 3. E #3 was hired on 6/24/2011 as a CNA. Documentation was lacking of a health screen having been completed prior to employment. Review of the as-worked nursing schedule between 6/24/2011 and 7/26/2011, indicated these employees had worked and had resident contact since date of hire. During an interview with the Wellness Director on 7/27/2011 at 4:30 p.m., he indicated that technically the Administrator was the one responsible for making sure all items were in the employees' personnel files, but guessed that he should be also, especially for the LPNs, CNAs and QMAs [Qualified Medication Assistant]. During an interview with the Wellness Director on 7/27/2011 at 5:20 p.m., he indicated he thought the physicals were in the files as he saw some of them, but after checking the files, he indicated he did not know why they were not there.		**deficient practice and what corrective action will be taken?** No other residents were found to be affected. Employee files were reviewed and findings were corrected via our policy and procedure by the Residence Director and Wellness Director. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director were re-educated as to our policy and procedure regarding employee health screen, signed job descriptions, Mantoux skin testing, and abuse continuing education for staff. Going forward staff will receive health screening and be given a PPD with verification of administration prior to resident contact. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director will perform a random monthly review of employee files for a period of four months to ensure completion of health screening, employee Mantoux skin testing, abuse training, and signed job descriptions. A review of the results will be conducted during Bennett House's QA program at the end of the fourth month. Findings suggestive of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			compliance will result in cessation of our monitoring plan.	
R0123	(h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to maintain personnel records for 4 of 5 new employee records reviewed in that job description and abuse training were lacking in a sample of 5 new employee files reviewed. (E #1, 2, 3, and 4) Findings include: On 7/27/2011 at 3:30 p.m., the files of new employees hired since 6/16/2011 were reviewed and the following was noted:	R0123	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this	09/05/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. E #1 [Employee] was hired on 7/3/2011 as an LPN [Licensed Practical Nurse]. Documentation was lacking of a job description and abuse training at time of hire. 2. E #2 was hired on 7/12/2011 as a CNA [Certified Nursing Assistant]. Documentation was lacking of a job description and abuse training at time of hire. 3. E #3 was hired on 6/24/2011 as a CNA [Certified Nursing Assistant]. Documentation was lacking of a job description and abuse training at time of hire. 4. E #4 was hired on 7/6/2011 initially as a CNA but subsequently became the Activity Director. Documentation was lacking of a job description for the CNA and Activity Director positions and of the employee having received abuse training at the time of hire. Review of the as-worked nursing schedule between 6/24/2011 and 7/26/2011, indicated these employees had worked and had resident contact since date of hire. During an interview with the Wellness Director on 7/27/2011 at 4:30 p.m., he		allegation by the survey agency. **R 123** **410 IAC 16.2-5-1.4 (h) (1-10)** **Personnel** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Employee #1, #2, #3, and #4 had a health screen completed and abuse training completed by the Wellness Director. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. Employee files were reviewed and findings were corrected via our policy and procedure by the Residence Director and Wellness Director. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director were re-educated as to our policy and procedure regarding employee health screen, signed job descriptions, Mantoux skin testing, and abuse continuing education for staff. Going forward staff will receive health screening and be given a PPD with verification of administration prior to resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated that technically the Administrator was the one responsible for making sure all items were in the employees' personnel files but guessed that he should be also, especially for the LPNs, CNAs and QMAs [Qualified Medication Assistant].		contact. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director will perform a random monthly review of employee files for a period of four months to ensure completion of health screening, employee Mantoux skin testing, abuse training, and signed job descriptions. A review of the results will be conducted during Bennett House's QA program at the end f the fourth month. Findings suggestive of compliance will result in cessation of our monitoring plan.	
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure a pre-admission assessment was initiated prior to admission for 4 of 4 residents reviewed with recent admission in a sample of 5. (Resident #1, 3, 4, 5) Finding included: 1. Review of the clinical record for Resident #1 [R] on 7/27/2011 at 2:20 p.m., indicated the resident was admitted	R0214	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or	09/05/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to the facility on 7/25/2011 and had diagnoses which included, but were not limited to, hypertension, status post cerebular stroke, history of prostate cancer, pacemaker placement and ischemic cardiomegaly. Documentation was lacking of a pre-admission assessment by a licensed nurse to establish a baseline for further evaluations and changes in condition. 2. Review of the clinical record for R #3 on 7/27/2011 at 2:00 p.m., indicated the resident was admitted to the facility on 6/28/2011 and had diagnoses which included, but were not limited to, diabetes mellitus, chronic ischemic heart disease, senile dementia, post operative anemia, and history of colon cancer. Documentation was lacking of a pre-admission assessment by a licensed nurse to establish a baseline for further evaluations and changes in condition. 3. Review of the clinical record for R #4 on 7/27/2011 at 12:45 p.m., indicated the resident was admitted to the facility on 7/7/2011 and had diagnoses which included, but were not limited to, gastrointestinal bleed, non-Hodgkin's lymphoma, diabetes mellitus, seizures, and atrial fibrillation. Documentation was lacking of a pre-admission assessment by a licensed nurse to establish a baseline for		agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.**What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident's #1, #3, #4, and #5 were reviewed and assessed by the licensed Wellness Director in accordance with our policy and procedure. Potential residents may be assessed by the house trifecta team as indicated within our policy and procedure. Residents who trigger nurse alerts will be communicated to the licensed nurse prior to admission for clinical oversight. The pre admission service level assessment and subsequent assessments may be completed by the sales manager, Residence Director, and/or Wellness Director prior to admission. The Wellness Director and/or licensed nurse will complete a Nursing Comprehensive Assessment within 7 days of move in as indicated within our policy and procedure. **R 214 410 IAC 16.2-5-2 (a) Evaluation** **We respectfully request a paper review of citation #3 via the IDR process based on attached information.How the facility will identify other residents having**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	further evaluations and changes in condition. 4. Review of the clinical record for R #5 on 7/27/2011 at 2:50 p.m., indicated the resident was admitted to the facility on 6/27/2011 and had diagnoses which included, but were not limited to, hypertension, hypothyroidism, and osteoporosis. Documentation was lacking of a pre-admission assessment by a licensed nurse to establish a baseline for further evaluations and changes in condition. During an interview with the Wellness Director on 7/27/2011 at 3:15 p.m., he indicated he did not do any pre-admission assessments of the residents prior to them coming into the facility as he did not know it was necessary. He indicated that the marketing director did all the preliminary interviews and paperwork on the residents prior to coming into the facility and that she was not a licensed nurse.		**the potential to be affected by the same deficient practice and what corrective action will be taken?**No other residents were found to be affected. The Wellness Director reviewed resident chart and implemented a spreadsheet to ensure timeliness of completion of the Nursing Comprehensive Assessment as indicated within our policy and procedure. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?**The Wellness Director, Residence Director, and Sales Manager was re-educated to our policy and procedure regarding the Service Level Assessment and Negotiated Service Plan along with the Nursing Comprehensive Assessment. The Wellness Director will review resident charts and document via a newly implemented spreadsheet to ensure completion of the Nursing Comprehensive Assessment as indicated within our policy and procedure. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**The Wellness Director upon hire had developed and implemented a spreadsheet to ensure semi annual evaluations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			were completed as indicated within our policy and procedure. The Wellness Director upon hire has conducted a QA of current residents and completed an updated re-assessment of residents utilizing our assessment tools per our policy. The Wellness Director is currently performing an ongoing monthly review of residents utilizing a spreadsheet she developed and implemented to ensure our assessment tools and completed per our policy. Potential residents may be assessed by the house trifecta team as indicated within our policy and procedure. Residents who trigger nurse alerts on the service level assessment will be communicated to the licensed nurse prior to admission for clinical oversight and intervention.	
R0216	(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure an evaluation of	R0216	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists	09/05/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	self administration of medication to administer insulin was done on 1 of 1 resident (R #4) in a sample of 5 residents reviewed for self administration of medications. Finding includes: Review of the clinical record for Resident #4 [R] on 7/27/2011 at 12:45 p.m., indicated the resident was admitted to the facility on 7/7/2011 and had diagnoses which included, but were not limited to, diabetes mellitus, seizures and non-Hodgkin's lymphoma. Review of the 7/7/2011 "Appendix B Service Assessment/Negotiated Service Plan", the evaluation indicated the resident needed the facility to manage all aspects of the resident's routine insulin administration, including safe disposal of all sharps. On 7/20/2011, new physician orders were received which indicated the resident was okay to self-administer his own insulin and for Lantus [an insulin] 14 units every morning. Documentation was lacking of an assessment having been completed by nursing to evaluate the resident to be sure he was capable and safe to administer his		or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.**R 216 410 IAC 16.2-5-2 (c) (1-4) (d) Evaluation We respectfully request a paper review of citation #4 via the IDR process based on attached information. What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident #4 was assessed by the prior Wellness Director with documented evidence of assessment located and faxed onto you for reconsideration. Resident #4 was re-assessed by the Wellness Director as to his/her ability to safely manage his insulin as indicated within the physician's order. The Wellness Director re-assessed this residents ability to safely store and administer insulin utilizing the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	own insulin. During an interview with the Wellness Director at 3:15 p.m., on 7/27/2011, he indicated he thought a physician's order was sufficient to allow the resident to self-administer his own insulin but that the resident did not do it himself - nursing did it for him. He indicated no self-administration of medication assessment had been completed. During an interview with QMA #1 [Qualified Medication Assistant] on 7/27/2011 at 3:20 p.m., she indicated the resident did do his own insulin on the days she worked and passed medications because she was not allowed as a QMA to administer insulin.		medication self administration assessment and was deemed capable of safe self management. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. The Wellness Director reviewed residents who self administer medications utilizing the medication self administration assessment with no other findings. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director was re-educated to our policy and procedure regarding resident self management of medication to ensure continued compliance. The Wellness Director will perform an ongoing review of residents who self administer medication through interview and implementation of the newly developed spreadsheet indicating periodic reviews as quarterly or when deemed necessary. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director will perform an ongoing review of residents who self administer	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			medication through interview and implementation of the newly developed spreadsheet indicating periodic reviews as quarterly or when deemed necessary.	
R0356	(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the emergency files contained a picture to identify 3 of 4 newly admitted residents (R# 3, 4, and 5) reviewed in a residential sample of 5 residents. Findings include: 1. Review of the clinical record and emergency file book for Resident [R] #3 on 7/27/2011 at 2:00 p.m., indicated the resident was admitted to the facility on 6/28/2011. Documentation was lacking of	R0356	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts	09/05/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a picture of the resident in the emergency file book in order to identify the resident in case of an emergency. 2. Review of the clinical record and emergency file book for R #4 on 7/27/2011 at 12:45 p.m., indicated the resident was admitted to the facility on 7/7/2011. Documentation was lacking of a picture of the resident in the emergency file book in order to identify the resident in case of an emergency. 3. Review of the clinical record for R #5 on 7/27/2011 indicated the resident was admitted to the facility on 6/27/2011. Documentation was lacking of a picture of the resident in the emergency file book in order to identify the resident in case of an emergency. During an interview with the Wellness Director and QMA #1 [Qualified Medication Assistant] on 7/27/2011 at 3:25 p.m., they indicated emergency file pictures were taken and placed into the resident's section of the emergency file book right away. They indicated they were out of film at this time which explained why some of the residents had them and some didn't or that a picture was only present in the medication book but not the emergency file book like it was supposed to be. They also indicated the emergency		alleged or the correctness of any conclusions set forth in this allegation by the survey agency.**R 356 410 IAC 16.2-5-8.1 (i) (1-8) Clinical Records What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident #3, #4, and #5 had emergency file information updated to include the following information as indicated with Indiana state ruling R 356 410 IAC 16.2-5-8.1 (i) (1-8) Clinical Records: (1) The resident' s name, sex, room or apartment, phone number, age, or date of birth. (2) The resident's hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident's physician of record. (5) The name and telephone number of the family members or other persons to be contracted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident. (8) Copy of advanced Directives, if available. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The Wellness Director reviewed the resident emergency file to ensure continued	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	file book was their care guide which contained the emergency file information, service plans and nursing notes and was the book they would grab in case of an emergency, not the medication book.		compliance with Indiana state ruling R 356 410 IAC 16.2-5-8.1 (i) (1-8) Clinical Records. Findings were identified and corrected through our QA process. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director and Residence Director was re-educated to Indiana state ruling R 356 410 IAC 16.2-5-8.1 (i) (1-8) Clinical Records. The Wellness Director will be responsible for periodic review of the emergency file to ensure continued compliance with the above mentioned information. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director will perform a random monthly review of the employee emergency file for a period of six (6) months. Findings will be reviewed within six months as to the plan regarding continued frequency of monitoring. Findings suggestive of compliance will meet the criteria for cessation of our monitoring plan.	